

§ 405.701 Basis, purpose and definitions.

(a) This subpart implements section 1869 of the Social Security Act. Section 1869(a) provides that the Secretary will make determinations about the following matters, and section 1869(b) provides for a hearing for an individual who is dissatisfied with the Secretary's determination as to:

(1) Whether the individual is entitled to hospital insurance (part A) or supplementary medical insurance (part B) under title XVIII of the Act; or

(2) The amount payable under hospital insurance.

(b) This subpart establishes the procedures governing initial determinations, reconsidered determinations, hearings, and final agency review, and the reopening of determinations and decisions that are applicable to matters arising under paragraph (a) of this section.

(c) Subparts J and R of 20 CFR part 404 (dealing with determinations, the administrative review process and representation of parties) are also applicable to matters arising under paragraph (a) of this section, except to the extent that specific provisions are contained in this subpart.

(d) *Definitions.* As used in subpart G of this part, the term—

Appellant designates the beneficiary, provider or other person or entity that has filed an appeal concerning a particular determination of benefits under Medicare part A. Designation as an appellant does not in itself convey standing to appeal the determination in question.

Common issues of law and fact, with respect to the aggregation of claims by two or more appellants to meet the minimum amount in controversy needed for a hearing, occurs when the claims sought to be aggregated are denied or reduced for similar reasons and arise from a similar fact pattern material to the reason the claims are denied.

Delivery of similar or related services, with respect to the aggregation of claims by two or more provider appellants to meet the minimum amount in controversy needed for a hearing, means like or coordinated services or

items provided to the same beneficiary by the appellants.

[55 FR 11020, Mar. 26, 1990, as amended at 59 FR 12181, Mar. 16, 1994]

§ 405.702 Notice of initial determination.

After a request for payment under part A of title XVIII of the Act is filed with the intermediary by or on behalf of the individual who received inpatient hospital services, extended care services, or home health services, and the intermediary has ascertained whether the items and services furnished are covered under part A of title XVIII, and where appropriate, ascertained and made payment of amounts due or has ascertained that no payments were due, the individual will be notified in writing of the initial determination in his case. In addition, if the items or services furnished such individual are not covered under part A of title XVIII by reason of § 411.15(g) or § 411.15(k) and payment may not be made for such items or services under § 411.400 only because the requirements of § 411.400(a)(2) are not met, the provider of services which furnished such items or services will be notified in writing of the initial determination in such individual's case. These notices shall be mailed to the individual and the provider of services at their last known addresses and shall state in detail the basis for the determination. Such written notices shall also inform the individual and the provider of services of their right to reconsideration of the determination if they are dissatisfied with the determination.

[55 FR 11020, Mar. 26, 1990]

§ 405.704 Actions which are initial determinations.

(a) *Applications and entitlement of individuals.* An initial determination with respect to an individual includes the following—

(1) A determination with respect to entitlement to hospital insurance or supplementary medical insurance;

(2) A disallowance of an individual's application for entitlement to hospital or supplementary medical insurance, if the individual fails to submit evidence